LCPC APPLICATION INSTRUCTIONS

1. **APPLICATION -** Applications are to be typed or printed legibly. All questions on the application must be answered.

*** All documentation must be original, on the forms currently in use by the Board and submitted as a complete application packet;**

*** Documentation containing white out or corrections will not be accepted by the Board.**

2. **FEE**: Application fee of $75.00 must be included with the application. Make your check payable to the Board of Professional Counselors and Therapists. **FEES ARE NON-REFUNDABLE.**

3. **OFFICIAL TRANSCRIPT(S):** Please have your college send your official transcript(s) directly to you in a sealed envelope. Send your sealed official transcript(s), the application, and the application fee to the Board in **ONE** packet. Please do not have the college or university mail the official transcript directly to the Board.

   The official seal of the college or university is required on all official transcripts with the date the degree was awarded/conferred.

4. **EDUCATION** – Applicants must hold a master's degree with a minimum of 60 graduate semester credits or 90 graduate quarter credits. For Doctoral Degree holders, 90 graduate credits or 135 graduate quarter credits. For both MA and PhD. **a minimum of 3 graduate semester credit hours or 5 graduate quarter credits in each of the following core courses:**

   - Human Growth and Development
   - Social and Cultural Foundations of Counseling
   - Counseling Theory
   - Counseling Techniques
   - Group, dynamics, processing and counseling
   - Lifestyle and Career Development
   - Appraisal of Individuals
   - Research and Evaluation
   - Professional, Legal and Ethical Responsibilities
   - Marriage and Family Therapy
   - Supervised Field Experience
   - Alcohol and Drug Counseling
   - Diagnosis and Psychopathology
   - Psychotherapy and Treatment of Mental Emotional Disorders

5. SUPERVISED CLINICAL EXPERIENCE –

Master's Level Applicant – 3/years/3,000 hours of supervised clinical experience in professional counseling. Of the 3 years, a minimum of 2 years/ 2,000 hours must be completed after the awarding of the master's degree and 100 hours of post degree face -to- face clinical supervision.

Doctoral Level Applicant- 2/years/2,000 of supervised clinical experience in professional counseling (1 year/1,000 hours must be post-doctorate) and 50 hours of post degree face -to-face clinical supervision.

6. EXAMINATION:

a. To become licensed by the Board applicants must pass the NCE of the NBCC and the Maryland Law Test.

b. After your application is received, reviewed and approved by the Maryland Board of Professional Counselors and Therapists you will be notified that you are approved to sit for the National Counselor Examination (NCE) and Maryland Law Test.

The National Board of Certified Counselors (NBCC) will be notified of your eligibility and you will be sent an examination registration form from the Board. Please go to our website, www.dhmh.maryland.gov/bopc for current examination dates. The NCE is now Computer Based and is administered on the first full week of each month. The Maryland Law test is administered at the Board's office, twice monthly.

Board of Professional Counselors and Therapists
4201 Patterson Avenue – Suite 316
Baltimore, Maryland 21215

MARYLAND APPLICATION FOR LICENSED PROFESSIONAL COUNSELOR

Maryland Board of Professional Counselors and Therapists
4201 Patterson Avenue
Baltimore, MD 21215 3rd Floor
410-764-4732
www.dhmh.maryland.gov/bopc

FOR OFFICE USE ONLY

LICENSE NUM/DATE:_____
NCE SCORE/DATE:_____
LAW SCORE/DATE:_____
BCKGRD RESULTS: _____
REVIEWER: _____
DATE REVIEWED:_____
COMMENTS:_____

TYPE OR PRINT ALL INFORMATION

VETERANS AND SPOUSAL PREFERENCE

1) Are you an active service member or the spouse of an active service member? Yes ☐ No ☐

2) Are you a veteran or the spouse of a veteran who was discharged from active duty under circumstances other than dishonorable within one (1) year of filing this application? Yes ☐ No ☐

DEMOGRAPHIC INFORMATION

Social Security No.	Date of Birth:	Place of Birth:

Name	Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐			
	Last Name	First Name	MI	Maiden

Home Address:	Street	City	County	State	Zip Code
If less than 3 years provide prior address.	Street	City	County	State	Zip Code
Mailing Address:(If different than above)	Street	City	County	State	Zip Code
Business Name and Address:	Name	Street	City / County	State	Zip Code

Home Phone:	Work:	Cell:	Email:

Province/Country if not U.S.

GENDER AND ETHNICITY: This information is optional and will be used for statistical purposes by authorized personnel.

Gender: ☐ Male ☐ Female

Ethnicity: Are you of Hispanic or Latino origin? Yes ☐ No ☐

Check all that apply.

☐ American Indian or Alaska Native ☐ Black or African American ☐ White
☐ Asian ☐ Native Hawaiian or other Pacific Islander

EXAMINATION

Have you successfully passed the National Counselors Examination (NCE)?

☐ Yes ☐ No

If answer is No, you must meet the education requirements before receiving approval by the Board to take the NCE and the Law test. Submit this application and supporting documents to enable the aboard to evaluate your education.

If the answer is Yes, please include documentation of passing score with the application.

Date of exam?	Exam Score

ADDITIONAL INFORMATION

a. Have you ever been denied an initial application, reinstatement or renewal of a license and /or certificate by any state licensing or disciplinary board?

☐ Yes ☐ No

If "yes" explain reason(s).

b. Has any state licensing or disciplinary board ever taken any action against your license and/or certification, including but not limited to limitations of practice, required education, admonishment, reprimand, revocation, suspension?

Yes ☐ No ☐

If yes, explain circumstance(s).

c. Has an investigation or charges ever been brought against you by any licensing or disciplinary board?

☐ Yes No ☐

If yes, explain circumstance(s).

d. Have you pled guilty, nolo contendre, or been convicted of or received probation before judgment or any criminal act (excluding traffic violations)?

☐ Yes No ☐

If "yes" provide the following information: Date of Conviction:

Where convicted Charge

If conviction was set aside, give date and explain using additional pages if necessary. Include required information on all felony convictions attaching additional sheets behind this page if necessary.

ACADEMIC TRAINING

Graduate college(s) or universities attended to satisfy academic requirements for licensure. Do not list degrees unrelated to Counseling. List most recent first and provide official transcripts.) Attach additional sheets behind this one, if necessary.

ALL APPLICANTS MUST COMPLETE THIS SECTION

Name of School:	
(City)	(State)
Inclusive dates attended: From (mo./yr.)	To (mo./yr.)
Degree granted:	Date granted (mo./yr.)
Major Field of Study:	
Name of School:	
(City)	(State)
Inclusive dates attended: From (mo./yr.)	To (mo./yr.)
Degree granted:	Date granted (mo./yr.)
Major Field of Study:	
Name of School:	
(City)	(State)
Inclusive dates attended: From (mo./yr.)	To (mo./yr.)
Degree granted:	Date granted (mo./yr.)
Major Field of Study:	
Name of School:	
(City)	(State)
Inclusive dates attended: From (mo./yr.)	To (mo./yr.)
Degree granted:	Date granted (mo./yr.)
Major Field of Study:	
Name of School:	
(City)	(State)
Inclusive dates attended: From (mo./yr.)	To (mo. /yr.)
Degree granted:	Date granted (mo./yr.)
Major Field of Study:	

SUPERVISED COUNSELING EXPERIENCE

NOTE: You may use up to 1,000 practicum/internship hours toward the overall 3,000 hours required for licensure

Practicum/Internship Experience(s)

1. Name of agency, school, organization where practicum/internship was obtained.

Name and credential(s) of supervisor:

Address of agency, school, or organization:

Inclusive dates of experience: From (mo./yr.) To (mo. /yr.)

a.

b.

Total number of months worked: Total number of hours worked per week:

Total number of hours worked during internship/practicum. (Number of months times 4, times number of hours worked each week.) _____

2. Name of agency, school, organization where practicum/internship was obtained

Name and credential(s) of supervisor:

Address of agency, school, or organization:

Inclusive dates of experience: From (mo./yr.) To (mo. /yr.)

a.

b.

Total number of months worked: Total number of hours worked per week:

Total number of hours worked during internship/practicum. (Number of months times 4, times number of hours worked each week.) _____

Professional Work Experience- After the degree date on the transcript
Supervised Work Experience that occurred after the award of the master's or doctorate degree Attached additional sheets behind this one, if necessary
Name of agency, school or organization:
Address of agency, school, or organization:
Telephone Number:
Inclusive dates of experience: From (mo./yr.) To (mo. /yr.)
Name, Title and Credential(s) of Supervisor:
a.
b.
Application's Job Title:
Job Duties:
Total number of months worked: Total number of hours worked per week:
Total number of hours worked: _____
Name of agency, school or organization:
Address of agency, school, or organization:
Telephone Number:
Inclusive dates of experience: From (mo./yr.) To (mo. /yr.)
Name, Title and Credential(s) of Supervisor:
a.
b.
Application's Job Title:
Job Duties:
Total number of months worked: _____ Total number of hours worked per week: _____
Total number of hours worked : _____

PROFESSIONAL REFERENCES:

List below at least (3) professional references who can attest to your counseling skills, professional standards of practice, and supervised clinical work.

ALL APPLICANTS MUST COMPLETE THIS SECTION

Name of Reference:

Degree Held: Certification/License Held:

Position Held:

Business name and address:

Business telephone number (include area code:

Will this reference be verifying some or all of your supervised clinical experience? ☐ Yes ☐ No

Name of Reference:

Degree Held: Certification/License Held:

Position Held:

Business name and address:

Business telephone number (include area code:

Will this reference be verifying some or all of your supervised clinical experience? ☐ Yes ☐ No

Name of Reference:

Degree Held: Certification/License Held:

Position Held:

Business name and address:

Business telephone number (include area code:

Will this reference be verifying some or all of your supervised clinical experience? ☐ Yes ☐ No

AFFIDAVIT

In making this application to the Maryland Board of Professional Counselors and Therapists for the issuance of a license, I agree to abide by the rules and regulations of the Maryland Board of Professional Counselors and Therapists and to take all examinations necessary to the processing of my application. Upon issuance of a license, I agree to be bound by the Code of Ethics. I further understand that the fee submitted with this application is NON-REFUNDABLE.

I agree to hold the Maryland Board of Professional Counselors and Therapists, its members, officers, agents, and examiners free from any damage or claim of damage or complaint by reason of any action taken in connection with this application, the attendant examination, the grades with respect to any examination, and/or failure of the Board to issue me a license. I hereby grant permission to the Board to seek any information or references it deems fit in securing my credentials pertinent to this application.

I understand, by law, it is my responsibility to notify the Board in writing if I change my address of residence.

I do hereby affirm that all statements made herein are true and correct to the best of my knowledge and belief. Furthermore, I voluntarily consent to a thorough review of the information in this application and other activities for the purpose of verifying my qualifications for licensure.

Signed _____

Date: _____

NOTARY
State of _____

City/County of _____

I HEREBY CERTIFY that on this _____ day of _____, before me, a Notary Public of the State and City/County aforesaid, personally appeared _____ _____, and made oath in due form that the contents of the foregoing Affidavit are true.

Notary Public _____
Commission Expires _____

ATTACH YOUR PHOTOGRAPH IN THIS AREA (RECENT 2”x2”)

COURSE DESCRIPTION FORM

COURSE FORM

Name	Address	Zip Code

I AM APPLIYING FOR **LCPC** ☐

Complete this form. Be sure to add your courses to total 60 credits or 90 qtr. credits for (MA degree) or 90 credits or 120 qtr. credits for (Ph.D.). All courses must b
graduate- level and from an accredited college. Each course must be at least 3-graduate credits or 5 Quarter credits. **A course applied to one core area cannot be used again to fulfill another core area.** Do not list courses unrelated to counseling. You must include college catalog description(s) or course syllabi if the titles of **your** courses are different from the courses listed on this form. **Applications will be returned if you do not include descriptions and you will be charged another review fee.**

Required Courses	Write in Course Number(s) & Course Title(s)	Credits Earned	College/University	Date	Grade
(a) Human Growth & Development					
(b) Social & Cultural Foundations of Counseling					
(c) Counseling Theory					
(d) Counseling Techniques					
(e) Group Dynamics, Processing & Counseling					
(f) Lifestyle & Career Development					
(g) Appraisal & Diagnosis of Individuals					
(h) Research & Evaluation					
(i) Professional, Legal & Ethical Responsibilities					
(j)Marriage and Family Therapy					
(k) Alcohol and Drug Counseling					

Required Courses	Write in Course Number(s) & Course Title(s)	Credits Earned	College/University	Date	Grade
(l) Supervised Field Experience					
(m) Diagnosis & Psychopathology					
(n) Psychotherapy and Treatment of Mental and Emotional Disorders					

Total credits earned ____

All applicants must show 60 graduate credits or 90 quarter credits. Applicants are eligible to take the National Examination and State Law Test upon completing the education requirements.

ADDITIONAL COURSES

Course Name	Course Number(s) & Course Title(s)	Credits Earned	College/University	Date	Grade

PROFESSIONAL REFERENCE FORMS

Three (3) references are required from three licensed professional counselors, or another mental health care provider, approved by the Board, who can address issues of professional education, professional supervised experience, competence, professional conduct, and moral character. At least one reference must be from the supervisor of your post-graduate clinical training. Do not list relatives, individuals with whom you have a close personal relationship or who work under your supervision.

RETURN REFERENCE FORMS IN A SEALED ENVELOPE WITH OTHER APPLICATION MATERIALS.

PROFESSIONAL REFERENCE ASSESSMENT FORM

Applicant's Name:

The applicant must complete items 1 and 3

The person named above has applied to the Maryland Board of Professional Counselors & Therapists to become a State Licensed Professional Counselor. Your assessment of the applicant's characteristics will enable the Board to evaluate whether this applicant meets its standards. Please respond to all questions to the best of your ability. (Questions 1,2 and 3 apply to reference). **PLEASE RETURN COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPE.**

1. Reference's Name :	Profession:
Business Address:	Degree:
	Position Title:
	Telephone:
2. Professional Certification or License:	
State or Certifying Organization:	
3. Relationship with applicant:	
☐ Trainer or Educator	Supervisor (Be sure to complete #5 on reverse side)
☐ Professional Colleague	Other

Length of time you have known this applicant: Dates from to

Please rate the applicant compared to other counselors you know on the following characteristics. Place a check in every category. (Counselor Educators should be evaluated on the basis of their ability to train students to counseling skill areas).

	Outstanding	**Above Average**	**Aver age**	**Below Average**	**Poor**	**Cannot Evaluate**
Individual Counseling skills	☐	☐	☐	☐	☐	☐
Appropriate referral making skills	☐	☐	☐	☐	☐	☐
Group counseling skills	☐	☐	☐	☐	☐	☐
Personal integrity	☐	☐	☐	☐	☐	☐
Consulting skills	☐	☐	☐	☐	☐	☐
Insight into client's problems	☐	☐	☐	☐	☐	☐
Ability to relate to co-workers	☐	☐	☐	☐	☐	☐
Ability to be objective on the job	☐	☐	☐	☐	☐	☐
Ethical conduct	☐	☐	☐	☐	☐	☐
Concern for welfare of clients	☐	☐	☐	☐	☐	☐
Sense of responsibility	☐	☐	☐	☐	☐	☐
Recognition of own limits	☐	☐	☐	☐	☐	☐
Supervisory abilities	☐	☐	☐	☐	☐	☐
Ability to keep material confidential	☐	☐	☐	☐	☐	☐

5. FOR SUPERVISORS ONLY: If you are verifying applicant's experience, you must complete this section.
I verify that this applicant for licensure as a Maryland Licensed Professional Counselor has spent
under my supervision in the following capacity:

Applicant's Position:	**Name of Agency/Institution:**
From (mo./yr.) **To (mo. /yr.)**	

_____
Supervisor's Signature

6. Recommendation: I recommend this applicant for licensure as a Maryland Licensed Professional Counselor.
☐ Yes ☐ No

Additional Comments:

7. Do you hold a current license to practice a: Professional Counselor : _____

LCMFT _____ **Psychologist:** _____ **LCSW-C:** _____

Other _____ (Specify) N/A: _____

8. The above information is based upon my best judgment. I am willing to answer additional questions concerning this evaluation if the Board deems it necessary.

_____ _____
Signature of Reference Date

After completing this form, please enclose it in a sealed envelope, sign the sealed flap and return it to this applicant.

REQUIRED CLINICAL SUPERVISED EXPERIENCE – LCPC

Years of Experience Required	Total Clinical Hours Required	Face-to-Face Client Contact Hours Required	Adjunctive Psychotherapy Or Support Therapy Hours	Face-to-Face clinical supervision hours Required
3 years required; 2 yrs. must be after the awarding of the master's degree	**3,000 hrs; 2,000 hrs**. must accumulated after the awarding of the Master's degree. **Note**: up to 1,000 masters level practicum/internship hrs. may be counted toward 3,000 hrs.	1,500 At least 1,500 required, however, you may have up to 3,000 hours.	1,500 (up to 1,500 may be included into the 3,000 total clinical hours)	100 hours after the awarding of the masters degree. Require a Minimum of 50 hrs of Individual sup; 50 may be Group Sup

Glossary of Terms

1. **"Face-to-face client contact hour" means direct session time with clients physically present.**

2. **"Adjunctive Psychotherapy" or "support therapy" means crisis intervention, referral, intake assessment, leadership in self-help group, consultation, guidance counseling, rehabilitation counseling, hospice and grief, school guidance counseling, career counseling, hypnotherapy, play therapy.**

3. **"Face-to-face clinical supervision" means direct supervision time with the supervisee and supervisor physically present. <u>These must be post MA hours.</u>**

4. **"Approved supervisor," means a licensed clinical professional counselor or another heath care provider under the Health Occupations Article, Annotated Code of Maryland. Examples: Psychologist, Psychiatrist, Clinical Social Worker, Psychiatrist Nurse**

"Clinical counseling" means engagement in professional counseling and appraisal activities by providing services involving the application of counseling principles and methods in the diagnosis, prevention, treatment, and amelioration of psychological problems, emotional conditions, or mental conditions of individuals or groups.

SUPERVISED CLINICAL DOCUMENTATION FORM

The Information provided on this form must be completed by the applicant's supervisor(s) at the agency or organization(s) where the applicant was employed for the period of time claimed. **This form should be photocopied and completed for each separate counseling experience claimed to meet the required clinical supervision including your practicum or internship, if applicable.** Please review the table and glossary of terms to help you understand the requirements.

APPLICATION DATE:

APPLICANT'S NAME AND CONTACT INFORMATION

Please Type or Print all Information:

1. Name:	Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐			
		Last	First	MI

2. Social Security Number:	
3.Name and address of organization, agency or any other counseling setting where the applicant gained supervised experience:	Name:

Address:					
Street	City	County	State	Zip Code	

4. Did this applicant perform 3,000 clinical hours under your supervision?

☐ Yes ☐ No. If no, how many hours

5. From:	To:
(Month/Day/Year)	(Month/Day/Year)

6. Did this applicant complete 1,500 face-to-face client contact hours under your supervision with client(s) physically present? ☐ **Yes** ☐ **No**

If no, indicate the number of hours:

7. Did you provide 100 post master's degree face-to-face clinical supervision hours with this applicant?

☐ **Yes** ☐ **No.** If no, indicate the number of hours:

100 post master's clinical supervision hours with the supervisor physically present is required. These hours must be completed after the transcript date the Masters Degree was conferred.

8 Are you a licensed Professional Counselor?

☐ **Yes** ☐ **No**

License Number: State: Expiration Date:

9. Are you licensed as another mental health care provider? ☐ **Yes** ☐ **No**

If yes, **where** are you licensed? State: License Number: Expiration Date:

10. As supervisor of this applicant, do you have any reservations about the applicant receiving a license for the independent practice of counseling? ☐ Yes ☐ No

If yes, please specify (attach additional sheet if necessary)

I VERIFY THE INFORMATION ON THIS FORM IS ACCURATE FOR THE APPLICANT

(Supervisor Print Name) (Supervisor's Signature)

Address:

(City) (State) (Zip) (Phone)

Witnessed by

Name of Notary